OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL INPATIENT DATA RECORD
MANUAL ABSTRACT REPORTING FORM
Effective with discharges occurring on or after January 1, 2009

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97216 through 97234)

TYPE OF CARE
1 Acute 5 Chem Dep
3 SN/IC 6 Physical Rehab
4 Psychiatric

FACILITY ID NUMBER

ABSTRACT RECORD NUMBER (Optional)

DATE OF BIRTH
Month | Day | Year (4 - Digit)

PATIENT'S SOCIAL SECURITY NUMBER
Report 000 00 0001 if SSN is Unknown

SEX
1 Male 3 Other
2 Female 4 Unknown

RACE
ETHNICITY
1 Hispanic
2 Non-Hispanic
3 Unknown

RACE
1 White
2 Black
3 Native American/ Eskimo/Aleut
4 Asian/Pacific Islander
5 Other
6 Unknown

ZIP CODE

ADMISSION DATE
Month | Day | Year (4 - Digit)

DISCHARGE DATE
Month | Day | Year (4 - Digit)

TOTAL CHARGES
(Report whole dollars only, right justified)

SOURCE OF ADMISSION
SITE
1 Home
2 Residential Care Facility
3 Ambulatory Surgery
4 SN/IC
5 Acute Inpatient Hospital Care
6 Other Inpatient Hospital Care
7 Newborn
8 Prison/Jail
9 Other

LICENSURE OF SITE
1 This Hospital
2 Another Hospital
3 Not a Hospital

ROUTE
1 Your ER
2 Not Your ER (or no ER)

TYPE OF ADMISSION
1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

EXPECTED SOURCE OF PAYMENT
PAYER CATEGORY
01 Medicare
02 Medi-Cal
03 Private Coverage
04 Workers' Compensation
05 County Indigent Programs
06 Other Government
07 Other Indigent
08 Self Pay
09 Other Payer

TYPE OF COVERAGE
1 Managed Care - Knox - Keene/ MCOHS
2 Managed Care - Other
3 Traditional Coverage

NAME OF PLAN
(0001 - 9999 Plan Code Number)

DISPOSITION OF PATIENT:
01 Routine (Home)
Within This Hospital
02 Acute Care
03 Other Care
04 SN/IC
To Another Hospital
05 Acute Care
06 Other Care (Not SN/IC)
07 SN/IC
08 Residential Care Facility
09 Prison/Jail
10 Against Medical Advice
11 Died
12 Home Health Service
13 Other

PREHOSPITAL CARE AND RESUSCITATION
DNR orders at admission or within 24 hrs of admission
Y = Yes
N = No

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL INPATIENT DATA RECORD
MANUAL ABSTRACT REPORTING FORM
Effective with discharges occurring on or after January 1, 2009

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97216 through 97234)

PRINCIPAL LANGUAGE SPOKEN

Enter only one 3-digit value in the space provided.
Or, if patient's Principal Language Spoken is not included in the list, then enter language spoken, up to 24 alpha characters.

ENG	English	LAO	Laotian
ARA	Arabic	HMN	Miao, Hmong
ARM	Armenian	KHM	Mon-Khmer, Cambodian
CHI	Chinese	NAV	Navajo
FRE	French	PER	Persian
CPF	French Creole	POL	Polish
GER	German	POR	Portuguese
GRE	Greek	RUS	Russian
GUJ	Guarathi	SCR	Serbo-Croatian
HEB	Hebrew	SPA	Spanish
HIN	Hindi	TGL	Tagalog
HUN	Hungarian	THA	Thai
ITA	Italian	URD	Urdu
JPN	Japanese	VIE	Vietnamese
KOR	Korean	YID	Yiddish
		999	Unknown

PRINCIPAL EXTERNAL CAUSE OF INJURY E-CODE

E | | | . |

PRESENT ON ADMISSION

Y = Yes
N = No
U = Unknown
W = Clinically Undetermined
blank = Exempt from POA reporting

OTHER EXTERNAL CAUSE OF INJURY E-CODES

PRESENT ON ADMISSION

E		.		
E		.		
E		.		
E		.		

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL INPATIENT DATA RECORD
MANUAL ABSTRACT REPORTING FORM
Effective with discharges occurring on or after January 1, 2009

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97216 through 97234)

PRINCIPAL DIAGNOSIS

PRESENT ON ADMISSION

Y = Yes
N = No
U = Unknown
W = Clinically Undetermined
blank = Exempt from POA reporting

OTHER DIAGNOSES / **PRESENT AT ADMISSION**

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
m.
n.
o.
p.
q.
r.
s.
t.
u.
v.
w.
x.

12. PRINCIPAL PROCEDURE AND DATE

Month | *Day* | *Year (4-Digit)*

13. OTHER PROCEDURES AND DATES

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
m.
n.
o.
p.
q.
r.
s.
t.